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TABLE OF CONTENTS

SECTION 1: INTRODUCTION TO THE TECHNICAL ASSISTANCE (TA) GUIDE

How to Use This Guide

Purpose

The *Healthy Love* Technical Assistance (TA) Guide is designed for use as a supplement to the *Healthy Love* Implementation Manual (IM) to assist agencies in implementing and maintaining *Healthy Love* with fidelity to the core elements and original design. The TA Guide provides an overview of key intervention information regarding planning, staffing, implementation, and maintenance of the intervention and answers to commonly asked questions.

Intended Audience

The *Healthy Love* TA Guide was developed as a resource for TA providers and agencies that are implementing the *Healthy Love* intervention. The TA Guide serves as a reference and starting point for obtaining TA but is not intended to be a substitute for expert TA providers.

Content

The content was informed by the experiences of SisterLove, Inc. (the agency that developed *Healthy Love*) and the case study agencies that field tested the intervention materials.

The TA guide has five sections:

- Section 1—Introduces the TA guide and describes how to use it
- Section 2—Provides an overview of *Healthy Love* and frequently asked questions (FAQs) related to the appropriate target population, benefits of implementing *Healthy Love*, and the appropriate intervention setting
- Section 3—Covers getting started and implementation of the intervention, including FAQs related to planning, staffing, implementation, and maintenance
- Section 4—Discusses the adaption of *Healthy Love* and consists of FAQs concerning fidelity, adaptation, and examples from the field
- Section 5—Describes monitoring and evaluation (M&E) of *Healthy Love*

SECTION 2: OVERVIEW OF *HEALTHY LOVE*

OVERVIEW OF *HEALTHY LOVE*

For more comprehensive information on the science behind *Healthy Love*, refer to the Overview section of the Implementation Manual (IM). The IM includes a description of the intervention and the research study, including the theoretical foundation of the intervention and the research outcomes. You will also find the *Healthy Love* Core Elements and the Behavior Change Logic Model in the IM. Quick Reference Guide tables are included throughout the TA Guide to direct you to where information can be found in the IM. Frequently asked questions are listed below each table to provide information that is not included in the IM but may come up while you are adapting this intervention in your setting.

Section 2 Quick Reference Guide

For More Information on:	See the Implementation Manual	See the Facilitator's Guide
Intervention Overview	Pages 3–5	
Science Behind the Intervention	Page 7	
Theoretical Foundation	Pages 8–9	
Core Elements and Key Characteristics	Pages 9–11	
Behavior Change Logic Model	Pages 11–13	
Implementation Summary	Page 34	
Facilitating the Intervention		Pages 57–132

Frequently Asked Questions

The following are the most commonly asked questions about the science (theoretical framework), core elements, key characteristics, and overview of *Healthy Love*. The questions are **bolded** and the answers appear below each question.

Q. What is the CDC diffusion of science-based interventions?

A. CDC has a national strategy to provide high-quality training and TA to prepare regional and community HIV programs to implement science-based HIV prevention interventions. CDC is collaborating with the original researchers to make effective interventions available to communities. For information about other effective interventions being diffused through CDC, visit the following CDC Web sites:

www.cdc.gov/hiv/projects/rep/default.htm

www.effectiveinterventions.org

Q. Do we have to implement *Healthy Love* exactly as it was done in the original research?

A. It is critical to implement *Healthy Love* as it was originally implemented to maintain fidelity. Maintaining fidelity helps to ensure results similar to those achieved during the original research. While you can adapt *Healthy Love* to fit the needs of your population, you must stick to the core elements (See the Adaptation section for more information.). However, you can alter the key characteristics of the intervention.

Q. Why must all of the agency's staff be oriented to the intervention?

A. It is important for all agency staff (including administrative assistants, counselors, and executive directors) to be aware of *Healthy Love*, particularly the eligibility requirements because it will allow them to provide referrals and/or screen agency clients, friends, and family for *Healthy Love* sessions.

Q. Why is it important for there to be two facilitators?

A. Two facilitators are recommended as a minimum to deliver the *Healthy Love* session; however, it is ideal for agencies to send a third facilitator to the Training of Facilitators (TOF). To maintain an upbeat and engaging session, facilitators take turns leading session activities or assisting their co-facilitator. Before a *Healthy Love* session, facilitators are assigned an equitable number of session activities to prepare materials for and be in charge of delivering. Facilitators rely heavily on each other throughout the session, as well as before the session for pre-implementation activities. If a third facilitator is available, this individual can assist with recruitment and post-intervention HIV testing and counseling or can serve as a facilitator if one of the other facilitators was unable to deliver the intervention.

Q. Why is it necessary for facilitators to have advanced training and experience in HIV/AIDS, STDs, sexual health education, and group facilitation?

A. *Healthy Love* is an interactive HIV/AIDS, sexually transmitted disease (STD), and sexual health education intervention. Facilitators provide information on a variety of topics, including basic HIV/AIDS and STD prevention information and prevention activities. The TOF does not review or provide training on basic HIV/AIDS or STD information. *Healthy Love* activities require facilitators to have basic knowledge of sexual health education. Thus, it is essential for facilitators to be able to answer questions about HIV/AIDS, STDs, and sexual health accurately. Finally, due to the interactive, upbeat, and high-energy nature of *Healthy Love,* it is very critical for facilitators to have basic facilitation skills. A Pre-Training Module covers basic facilitation skills required by *Healthy Love*. During the TOF, facilitators have an opportunity to refine their skills; however, neither the TOF nor Pre-Training Module are designed to be courses on basic group facilitation. At minimum, it is strongly recommended that facilitators attend a basic group facilitation course and HIV/AIDS and STD 101 before delivering *Healthy Love*.

Q. What is an appropriate age group for *Healthy Love*?

A. During the original research, the target population was 18 years or older. On the basis of the experience of agencies that tested the implementation package, some older women (i.e., women over 50 years) did not feel comfortable sharing their experiences in a mixed age group; they would have preferred a group with women in their same age cohort. Thus, when scheduling a *Healthy Love* session, it is important to consider the diversity of ages in the group, especially if it is not a pre-existing group. If only one or a few participants are older than the rest of the participants, you will need to determine their comfort level being with younger participants. If they do not feel comfortable, it may be better to refer them to other services and/or postpone their participation until you can connect them with participants in their same age group.

Some agencies may consider implementing *Healthy Love* with adolescents. The Adaptation section provides some general guidance for adapting the intervention for other populations; however, technical assistance is highly recommended for agencies that choose to adapt *Healthy Love* for such a population.

SECTION 3: GETTING STARTED AND IMPLEMENTING *HEALTHY LOVE*

GETTING STARTED

Planning

There are a number of factors to consider before implementing *Healthy Love*. For example, how many and what kinds of staff members should you hire, and how much time and effort should your agency allocate to pre-implementation and implementation activities? For more information, provided in the Pre-Implementation section of the IM, please refer to the table below.

Section 3 Quick Reference Guide

For More Information on:	See the Implementation Manual	See the Facilitator's Guide
Agency Fit and Capacity; Readiness to Implement the Intervention	Pages 14–16; 27-29	
Stakeholder Buy-In	Pages 17–22	
Identifying Appropriate Staff	Page 22–26	
Preparing for Implementation "Facilitation Coordination and Implementation At-A-Glance"	Page 42–48	
Client Recruitment and Marketing	Pages 29–30; 43–44; 46	
Introduction to the Facilitator's Guide	Page 57	
Session At-A-Glance	Page 48–49	
Quality Assurance Plan	Pages 137–138	
Monitoring and Evaluation Plan	Pages 138–146	
Developing an Evaluation Plan	Page 138–139	

Staffing

Each agency should have its own policies and procedures that include guidance on hiring staff. The *Healthy Love* staff roles and responsibilities are on pp. 2– of the IM. For successful implementation of *Healthy Love,* you will need the following staff:

- One program manager to plan for the implementation of *Healthy Love*
- At least two skilled facilitators with experience delivering HIV/STD prevention interventions to implement the intervention
- One administrative assistant to support the program manager and facilitators in carrying out pre-implementation and implementation activities as appropriate

Frequently Asked Questions

The following are a number of questions that agencies preparing to implement *Healthy Love* have asked.

Q. If I cannot locate facilitators with the knowledge or facilitation skills that are needed, what can I do?

A. The facilitator knowledge and skills required are outlined on pp. 2–2 of the IM. If you are unable to locate individuals with the facilitation knowledge or skills needed to implement *Healthy Love*, consider providing training to your existing staff to build their skill set. If you do not have funding to train your staff members, consider partnering with a local agency that has staff members with the appropriate skills. It is suggested that facilitators attend any local trainings that are being offered to help bolster their facilitation skills. The following are some examples of these trainings and who offers them:

Course	Provider
Group Facilitation	Prevention Training Centers (PTCs) Capacity Building Assistance provides (CBAs)
Bridging Theory and Practice	PTCs and CBAs
STD 101	PTCs
HIV 101	American Red Cross
Recruitment and Retention	CBAs

Trainings to enhance HIV/AIDS knowledge are always being offered, and many of these trainings can be found on CDC's Web site training events calendar:

https://wwwn.cdc.gov/GEMS/Pages/Main/Agreement.aspx

Q. Is it okay to have fewer staff members because of budget issues?

A. Two facilitators are required for the implementation of *Healthy Love.* One way to possibly reduce costs is to not hire an administrative assistant and have the facilitators do the marketing and recruitment, pre-implementation, and follow-up activities. If you choose this option, be careful not to overload your facilitators with other agency responsibilities. Another alternative is to have interns or volunteers assist with the marketing and recruitment, pre-implementation, and follow-up activities.

Q. May I use volunteers instead of agency staff to implement *Healthy Love*?

A. Volunteers and interns may assist with the marketing and recruitment, pre-implementation, and follow-up activities. Volunteers or interns should not facilitate sessions unless they are skilled facilitators and possess all of the knowledge, characteristics, and skills that are outlined on pp. – of the IM, and have attended the *Healthy Love* TOF.

Q. Do the facilitators who conduct the intervention need to be the same race/ethnicity as the participants?

A. It is recommended that staff be the same race/ethnicity as the participants. Therefore, if you plan to implement with mixed groups (i.e., African American and Caucasian women), if possible you should have a Caucasian facilitator and an African American facilitator. If this is not possible, the most important thing is to ensure that your facilitators can relate to the participant population—a core element of the intervention. Therefore, being culturally competent is one of the requirements that should be considered when selecting facilitators. Activity 7, **The Look of HIV Among African American Women**, provides participants an opportunity to discuss HIV/AIDS among their racial/ethnic group. Another core element for *Healthy Love* requires that facilitators possess the ability to discuss sensitive information in a nonjudgmental, culturally appropriate, and safe environment.

Q. Do the facilitators who conduct the intervention need to be the same gender as the participants?

A. To establish a comfort level and a safe space, facilitators must be the same gender as the participants. Also, *Healthy Love* was originally designed by African American women for African American women. One of the core elements of the intervention is to implement *Healthy Love* with a skilled group facilitator who is the same gender as participants. This component of the intervention should not be changed.

Q. Can I use peers to facilitate *Healthy Love*?

A. Peers can facilitate sessions as long as they possess all of the knowledge, characteristics, and skills outlined on pp. 26–28 of the IM and have attended a *Healthy Love* TOF to be trained on the intervention. In addition, facilitators must have the knowledge, skills, and abilities needed to deliver the content in an upbeat, energetic, and engaging manner.

Q. Where do we find people with the skills to be facilitators?

A. Various approaches and resources are available to find skilled facilitators. The first place to look is within your own agency to see whether you have staff members who are qualified and available to work on *Healthy Love*. To find facilitators outside of your agency, try the following:

- Ask your Community Advisory Board (CAB) for recommendations
- Talk with staff members of other local HIV/STD programs
- Check with your local health department
- Check the public health, social work, and education programs at local colleges

Q. If a potential facilitator does not have group facilitation experience, how can they get training?

A. Group facilitation is a critical skill needed to deliver this intervention. A successful facilitator knows how to deliver the content and manage group dynamics. *Healthy Love* is a fast-paced, high-energy intervention; facilitators need to have group facilitation skills to manage the pace and deliver content accurately.

Group facilitation trainings or workshops are often offered by local colleges or universities, PTCs, and CBA providers. First, conduct some research to find out what is being offered, where it is being offered, and how much it costs. Next, discuss the options with the potential facilitator to determine whether training is worth pursuing. Group facilitation skills are not taught during the *Healthy Love* TOF; facilitators are expected to possess these skills before attending. The *Healthy Love* Pre-Training Module reviews basic group facilitation skills that Healthy Love facilitators must possess; facilitators are required to review this module before attending the training.

Q. How can I train staff members who were not able to attend the *Healthy Love* training?

A. *Healthy Love* facilitators are required to complete the *Healthy Love* TOF, a 2-day training that teaches participants how to implement the intervention with fidelity. In addition to the *Healthy Love* TOF, facilitators are required to complete prerequisite training on the basics of HIV/AIDS and STD prevention, as well as general group facilitation. Staff members who were not able to attend the *Healthy Love* TOF should have opportunities to attend a future *Healthy Love* TOF. (See www.effectiveinterventions.org for potential training dates.) While they wait for a *Healthy Love* training to become available, it is suggested that facilitators take basic trainings on group facilitation, HIV/AIDS, and STDs to enhance their skills and knowledge.

Q. How can I request training for my agency?

A. Facilitators need to attend an official *Healthy Love* training that is not offered to individual agencies. To access training schedules CDC-funded agencies can visit www.effectiveinterventions.org. If funded through a State health department, contact your representative to request (on your behalf) a CDC-sponsored training for your staff. Program managers are also encouraged to view the online *Healthy Love* Program Managers Module to become more familiar with the intervention information.

Q. I have a coworker who would be a great *Healthy Love* facilitator. Can she implement the program even without formal training?

A. It is recommended that all facilitators attend the *Healthy Love* TOF. Ultimately, an agency's funding source will dictate an agency's responsibility for the training and implementation of the intervention. Organizations directly and indirectly funded by CDC that use those funds to deliver this intervention as part of their prevention portfolio are required to send facilitators to the formal intervention TOF and to implement the intervention with fidelity.

IMPLEMENTING

The *Healthy Love* Facilitator's Guide is designed to provide step-by-step guidance on how to prepare for and deliver the *Healthy Love* intervention with fidelity. The first part of the Facilitator's Guide provides an overview of the intervention and facilitator requirements. Identifying and training appropriate and skilled facilitators on how to deliver the intervention will help to ensure successful implementation.

Following the guidance provided and delivering the *Healthy Love* sessions as scripted in the Facilitator's Guide will help to ensure that participants will experience the full benefit of the intervention. *Healthy Love* is an evidence-based intervention (EBI); thus, if delivered as intended, facilitators can help to bring about positive changes in women's knowledge, attitudes, beliefs, and

behaviors to prevent HIV/AIDS and STDs and improve women's sexual health and sexuality, as shown in the original research. Facilitators are strongly encouraged to thoroughly review and familiarize themselves with the contents of the Facilitator's Guide and supporting materials provided in the appendix. Finally, it is recommended that facilitators discuss the information contained in the Facilitator's Guide with their supervisors and develop agency-specific plans for implementation of *Healthy Love*.

Frequently Asked Questions

Q. How do you keep staff motivated after the training?

A. Encouraging staff to begin *Healthy Love* activities soon after the training will help to keep them motivated. Maintaining staff support for *Healthy Love* over several years involves preventing and managing facilitator burnout, keeping the intervention interesting for facilitators, dealing with staff turnover, balancing facilitators' additional responsibilities within the agency, and incorporating *Healthy Love* into your agency's mission.

Q. Is there a *Healthy Love* attendance policy?

A. *Healthy Love* is a single-session intervention, so there is no policy on the number of sessions missed. The minimum number of attendees recommended for a session is five; anything smaller than that is not recommended. The largest number is 14 for a session. Facilitators should ensure that participants are available for 3–4 hours (not including breaks, or HIV testing if provided).

Q. How do I make certain that all my participants show up to the session?

A. The best way to make sure that all (or at least the majority) of your participants show up to the session is to establish contact with them leading up to the session and to provide a reminder call/or e-mail the day before the session. If you are working with a site contact who will not allow you to have the participants' contact information, it is important that you contact that individual multiple times leading up to a session to ensure that the participants are getting reminders of the session date, time, and location. The following are some additional tips on how to ensure that participants show up for sessions:

- Always overbook. The minimum number of participants required for a *Healthy Love* session is five; therefore, you should always try to recruit more than five participants for each session. It is better to book a higher number of participants because of cancellations or no-shows.

- Schedule sessions within 1–2 weeks after speaking with your site contact. Do not schedule sessions too far out from that initial meeting.

- Once scheduled, follow up with the *Healthy Love* session requestor via phone or e-mail at least three times (within a 2-week period) before the session to ensure you are still on track to deliver the intervention on a specific date/time. Ensure that a response is received following each communication and address any challenges/concerns in a timely manner.

- Work with pre-existing groups of women that your agency has worked with in the past.

- Consider working with groups of women who would be court-ordered or required to attend sessions similar to *Healthy Love* (e.g., women in group homes or correctional settings).

- Work with another agency to offer child-care services for 3–4 hours of the session and advertise this on your marketing and recruitment materials.

- Advertise free food, snacks, or other incentives on your marketing and recruitment materials if you plan to provide them.

- Most importantly, advertise that the sessions are fun!

Q. What if only one of the two facilitators can be present?

A. Because facilitators rely so heavily on their co-facilitators when delivering *Healthy Love*, it is best to reschedule for a day and time that works best for both facilitators. If rescheduling is not feasible, try to find a volunteer to assist with writing on newsprints and other activities, such as passing out session materials to participants. In addition, if there is only one facilitator and a volunteer and your agency offers HIV testing in conjunction with *Healthy Love,* you may want to offer HIV testing and counseling on another date and time. Provide participants HIV testing cards that include a date and time for them to come to your agency to be tested.

Q. What if the session frequently runs longer or shorter than the suggested length of time?

A. Research conducted on the 3- to 4-hour single sessions showed the effectiveness of the original *Healthy Love* design. If at all possible, you should adhere to this same design. It is recommended that the agency first determine whether time is a consistent issue or not. Next, the facilitators need to assess the number of participants in the session, as that could be a factor in making the session longer or shorter. If a session is shorter than 3 hours, facilitators should assess whether participants were engaged in the session, activities were properly followed and processed, and the number of participants (perhaps a smaller group) affected the amount of time that it took to deliver the intervention. These factors can be used to improve timing of future deliveries of the intervention, if needed.

If a session runs longer, participants may become tired or think they were misled about their *Healthy Love* time commitment. Facilitators should practice their delivery and manage group dynamics to stay within the 3- to 4-hour timeframe. For example, the Kitchen Table is a tool that was designed to help facilitators limit discussions that run too long. Facilitators should use this tool when participants are asking many questions and review all the questions at the end of the session.

Q. Can a *Healthy Love* session be divided into 2 days?

A. Yes. If your participants cannot commit to 3–4 hours and are not opposed to attending a 2-day session, you can divide the session in half. If you decide to break the session into 2 days, it is recommended that you end day 1 with Activity 7, **The Look of HIV Among African American Women** and begin day 2 with Activity 8, **A Trip Down Memory Lane**. The reason for this is to begin and end each day with an upbeat activity. When you begin day 2, be sure to have the music playing as participants enter the room to set the tone for the rest of the session.

Q. Are people who are not participants allowed to attend the sessions?

A. To create a safe space, only *Healthy Love* participants should attend sessions. You will need to carefully assess on a case-by-case basis whether allowing someone to observe would negatively impact the session. Due to the nature of the material that will be discussed, children (including teenagers) should not attend sessions; you should specify this on your marketing and recruitment materials. If your agency is able to provide child-care services for the session, note that on your marketing and recruitment materials. This will be an incentive for parents who do not have child-care available.

Q. What do you do if participants show up with infants or children?

A. During the planning process, it is important to think about your target population. Because *Healthy Love* is designed for African American women aged 18 years or older, you should anticipate that you may need to provide child-care services for the 3–4 hours. If your agency is able to provide this service, be certain to mention it on your marketing and recruitment materials. If your agency is unable to provide this service, make sure to let participants know that children (including teenagers) are not allowed to attend the session and that child care will not be provided. A woman who brings a child should not be allowed to stay if you elect to move forward with the session. An agency policy for this should be developed to help facilitators know how to negotiate these situations.

Q. What types of agencies have used the *Healthy Love* intervention?

A. A variety of organizations have implemented *Healthy Love* as part of their prevention portfolio. These include CBOs that provide HIV prevention services, faith-based organizations, agencies that provide recovery services,

organizations that provide direct and indirect services to persons living with HIV/AIDS, and agencies that assist the homeless.

Q. Can the program be conducted in places other than community-based settings, such as group homes or correctional settings?

A. *Healthy Love* can be conducted in churches, participants' homes, group homes, correctional settings, dormitories, conference rooms, or wherever participants feel safe and comfortable. Please note that if you choose to host a session in a church, you should conduct the session in a conference room or basement if possible (versus the main sanctuary) to ensure privacy. If you plan to host a session in someone's private residence, try to check out the space before the session to ensure you have enough room. Also, receive permission from the host to post newsprints and other session materials on their walls before doing so.

Q. Is it better to have a session during the evening or the morning? Is during the week or on the weekend better for holding a session?

A. Deciding when to hold a session depends on participants' preference and facilitators' availability. When scheduling sessions, keep in mind that some participants may work and may have children. In the evenings, they may have other commitments or be tired and less energetic at this time. Others may not be available in the mornings or during the weekends for a session. Do your best to work around participants' schedules and keep the session as fun and exciting as possible to keep individuals engaged. Take small breaks and provide light snacks and child care if necessary.

Q. A single session lasts 3–4 hours, which seems like a long time. Will participants get tired?

A. The allotted time for the session will go much faster than you anticipate. When conducting a session, pay close attention to your participants' body language. If you think they need a break, offer a brief stretch break, or stop and encourage participants to grab a snack or beverage. Some groups will prefer not to take breaks and to continue straight through. Each group will vary, and you will have to adjust accordingly. If you host a session in a substance abuse recovery setting, take into consideration that these participants may need to take more than one or two breaks during the 3- to 4-hour session. For this population, it is also recommended that you provide snacks and beverages, if possible.

Q. If my agency wants to offer HIV testing in conjunction with sessions but does have this capability, what should we do?

A. If your agency does not provide HIV testing but would like to offer it in conjunction with the sessions, consider partnering with another agency or with your local Health Department. Invite the partnering organization to attend the session to attend the sessions with your facilitators and provide testing at the

end of the sessions. Alternatively, check to see if a CTR provider is available to come to your agency on specified dates and times to offer testing to those participants who have completed a session.

Q. If a session is conducted in a participant's private residence, where do you post all the newsprints?

A. Before holding a session in someone's private residence, it is recommended that you conduct a site visit to see the space where you'll implement the intervention. Ensure that you get permission from the host to post newsprints on the walls. It is also suggested that you only post the newsprints that are pertinent to the activity at hand. The other newsprints can be removed from the walls. The Expectations and Ground Rules newsprints should remain posted, if possible. As you take newsprints down, stack them in order so you can easily refer back to them if necessary. Try to use all the space available in the room, including floor and table space.

Q. Can family members (brothers and sisters or husbands and wives), couples, or close friends participate in the same group setting?

A. *Healthy Love* was originally designed to be implemented with affinity groups of women; therefore, close friends and family members can participate, however, husbands, brothers, and significant others should not participate at the same time as their partners or sisters. See the Adaptation section for additional information on other populations that *Healthy Love* can be implemented with.

Q. Do we need permission to translate the intervention materials into another language?

A. It is not necessary to receive permission to translate intervention materials into another language, but you should consider the impact on all of the intervention materials (e.g., fact sheets, handouts). You may also want to share the materials with your local Program Review Board. It is important that the materials be translated correctly, so work with a reliable translator.

Q. Does someone at CDC need to review or approve changes we want to make to intervention materials?

A. It is recommended that your local CAB review your changes and provide feedback before you start implementing. If you are directly or indirectly funded through CDC, you should discuss proposed changes to the intervention materials with your Project Officer. If adapting the intervention, it is recommended that you seek technical assistance for further guidance.

Q. Can we modify and change materials (statistics, posters, and handouts) to update the intervention?

A. Statistical information on HIV/AIDS will change and should be updated as needed. *Healthy Love* also has additional handouts and posters that should be updated as needed. These materials can also be modified for the participants who are attending the session.

Maintenance

Frequently Asked Questions

The following are FAQs that agencies have asked related to maintaining the intervention.

Q. What can we do to minimize interruptions in services when we have facilitator turnover?

A. The best way to minimize interruptions in services is to send more than two facilitators to the *Healthy Love* TOF. It is ideal to train at least three to four facilitators. If you experience staff turnover, try to partner with an agency that also has staff trained in *Healthy Love* until you can hire and train new staff members.

Q. We feel like we have reached the target population in our area with *Healthy Love* sessions. How do we reach new participants?

A. If you feel that you have reached the target population in your area, the first step is to review your paperwork (e.g., sign-in sheets) and determine whether you can target a different age group. It is possible that you may not have exhausted all age groups. Another recommendation is to try and establish new partnerships, which can assist you in receiving new referrals for *Healthy Love* sessions. If you are a small community and/or rural area and over time you have reached all women who are eligible to participate in a *Healthy Love* session, you may want to consider adapting *Healthy Love* for other populations (see the Adaption section).

Q. What are some ways to keep sessions upbeat and fun?

A. The following are some suggestions on how to keep sessions upbeat and fun:

- Have confidence in your abilities as a facilitator
- Have fun with the materials
- Infuse humor when appropriate

- Use music (where appropriate) to create an energized and fun environment and to set the tone for the intervention
- Make the session relevant to participants (i.e., answering participants' questions and relating the intervention content to examples provided by individuals in the session).

SECTION 4: ADAPTING *HEALTHY LOVE*

ADAPTATION

Adaptation is the process of modifying an EBI to meet a particular population's needs while maintaining fidelity to the intervention's core elements and original intent. *Healthy Love* has been adapted to be implemented with women from different racial/ethnic groups and sexual orientations. While the *Healthy Love* core elements must remain intact when the intervention is adapted, activities can be altered to meet the needs of a new population.

The adaptation process consists of a number of analytical steps, including a community assessment of your target population's HIV prevention needs and determinants of behavior change; reviewing existing interventions; assessing community support and norms; making necessary changes to fit your target population; and testing new materials. A critical component of the process is working with members of your target population and key stakeholders during each step to ensure your target population's needs are addressed and the materials are culturally and linguistically competent and age appropriate.

The following are a few adaptation tips:

- Adapt *Healthy Love* to address all or one of the following:
  - Your intervention population's readiness or willingness, interest, and ability to participate in the intervention
  - Your agency's readiness or current and/or future capacity and resources to provide the intervention
- Do not adapt *Healthy Love* for a different risk behavior; to address different risk behaviors, select a different intervention that better fits the needs of your target population and their risk behaviors
- Review the behavior change logic model and understand how activities work to achieve their outcomes
- Learn how to break down *Healthy Love*'s intervention activities into who, what, when, where, how, and why
  - Who describes the intervention population or the people who deliver the intervention
  - What describes the content, images, and/or messages of the activity, including such things as the images of African American women on recruitment posters or other marketing materials

- When describes the timing, length, and order of the activities
- Where describes the locations where the intervention is conducted, including in a clinic or in a community setting
- How means how the activity is conducted (e.g., group discussion, lecture, role-play, demonstration)
- Why describes the intent or purpose of the activity and explains the reason an activity is done in a certain way (who, what, when, where, how, and why) to get a certain result; the why of an activity or intervention can never be changed

- Before adapting *Healthy Love*, identify what activities will be changed, why they will be changed, and how they will be changed; organizations directly or indirectly funded by CDC should check with their Project Officers before moving forward with an adaptation
- Test and revise adaptations to gain useful feedback for making changes
- Implement, evaluate, and revise *Healthy Love*

Frequently Asked Questions

The following are FAQs about adaptation.

Q. If we want to change something in a handout, how should we go about making those changes?

A. Use the tips above to revise the handout. Before making any changes, identify why the handout needs to be changed. On the basis of your decision, identify what changes need to be made and how those changes will be made. Remember, changes to handouts should be made for one or both of the following reasons:

- Population needs—For example, you're implementing the intervention with a different target population (e.g., implementing *Healthy Love* with groups of women of mixed race/ethnicity)
- Agency needs—For example, resources and/or capacity

Revise the handout to meet the needs of the community. Ask a few members of the target population, program review board, and community to review and provide feedback on the revised handout. Incorporate the feedback received and revise the handout. Implement the revised handout and note participant feedback and revise, if necessary, before the next intervention cycle.

Q. How can *Healthy Love* be adapted for groups of women of different races/ethnicities?

A. *Healthy Love* can easily be adapted for women of different races/ethnicities. One of the first things an agency would need to do is locate and hire facilitators who match the ethnicity of the intervention audiences. Having a facilitator who matches the ethnicity of a majority of the participants is one way to make the delivery culturally appropriate and competent. In addition, a culturally competent facilitator will be able to translate the content into a specific and relevant cultural perspective. The following are some quick tips on adapting specific activities for a different racial/ethnic group:

- Activity 3, **Synonyms**—Some cultures have specific taboos, customs, or beliefs about sexual expression and anatomy. Specifically, some cultures have different names for anatomy and the activity needs to be adapted to reflect the culturally appropriate names.

- Activity 7, **The Look of HIV Among African American Women**—This activity specifically examines some of the attitudes and beliefs of the African American community. Adapt this activity by updating the statistics for the relevant community, adding relevant cultural attitudes and beliefs (myths) and any other relevant cultural risk factors.

- Activity 8, **Trip Down Memory Lane**—This activity uses music and reflection to help participants assess their risk behaviors (past and present). Adapt this activity with music that is relevant to the culture (including age group and other important cultural distinctions). Additional adaptations include asking questions that explore specific cultural experiences that can influence risk-taking behaviors.

- Activity 12, **Other Safer-Sex Tools**—This activity reviews other safer-sex activities including condom negotiation. Adapt this activity by making the negotiation demonstration and accompanying handout culturally relevant to the audience.

Q. For what other populations can Healthy Love be adapted?

A. *Healthy Love* may be adapted for men (MSM and heterosexual) as well as transgendered individuals depending on the needs of the target population. A major part of the adaptation will come in the form of different and additional processing questions for specific activities (i.e., Activity 2, Synonyms; Activity 6, The Look of HIV Among African Americans; Activity 8, Trip Down Memory Lane; and Activity 11, Female Condom Demonstration) to tailor them for a specific population. Agencies contemplating adaptation for these populations should consult with their project officer or funder for specific requirements. It is also advisable to seek technical assistance to ensure that through the adaptation process the core elements and original intent of the intervention are maintained.

SECTION 5: MONITORING AND EVALUATION

MONITORING AND EVALUATION

There are a number of reasons an agency may want to monitor and/or evaluate an intervention. Monitoring and evaluation (M&E) ensures accountability to the community, their staff, clients, and funding source; it also helps to improve the quality and delivery of the intervention. Evaluation helps an agency decipher what worked and did not work, which is important to effectively improve and adapt its programs. For more information on the types of evaluation your agency will conduct and why, refer to the Maintenance section of the IM.

Section 5 Quick Reference Guide

For More Information on:	See the Implementation Manual	See the Facilitator's Guide
Developing a Quality Assurance Plan	Pages 138–139	
Type of Monitoring and Evaluation	Pages 139–142	
Program Monitoring and Evaluation	Pages 142–144	
Data Collection, Management and Analysis	Pages 144–146	
Reporting and Using Evaluation Data to Improve the Program	Page 146	
Developing an Evaluation Plan	Page 146	

Frequently Asked Questions

Q. Do we have to use all of monitoring forms included in the *Healthy Love* Implementation Manual appendices?

A. Facilitators should use the following M&E forms when implementing *Healthy Love*:

- Pre- and Post-Session Knowledge Assessments
- *Healthy Love* Participant Evaluation Form
- *Healthy Love* Facilitator Session Report Form

Additional monitoring and tracking documents may be developed as part of the M&E plan for the intervention and your agency. These forms will provide the information needed to conduct basic monitoring and evaluation activities.

Q. Can we change the pre- and post-knowledge assessment forms?

A. The questions on the pre- and post-knowledge assessment forms were designed to assess knowledge gained among participants. These questions have been tested among the target population for validity and therefore should not be changed.

Q. What is the difference between process evaluation and process monitoring?

A. Process monitoring is the most fundamental monitoring activity. It involves the collection of basic data throughout the duration of the program. Process monitoring data focus on the characteristics of the women attending the program, the number of sessions delivered to groups of women, resources used to deliver the program, the information and skills building provided during the sessions, and modifications made to program sessions.

Process monitoring is required if your agency receives funding directly from CDC for HIV prevention or if you receive CDC funding indirectly from your health department. Check with your Project Officer for all of the process monitoring requirements based on your funding source. Process monitoring and other program M&E activities are requirements for CDC's National HIV Prevention Program Monitoring and Evaluation (NHM&E).

Process evaluation is the first type of evaluation your agency can conduct. It can be defined as the process of collecting more detailed data about how the intervention was delivered, any differences between the implementation plan and actual implementation, and access to the intervention.

Process evaluation takes data collected during process monitoring activities and compares that information to your agency's implementation plan. It compares what actually happened to what was intended to happen. This includes both the characteristics of participants and activities conducted.

Q. How are the process monitoring data used to inform the implementation of *Healthy Love*?

A. Because the process monitoring data allow you to track information such as the number of sessions conducted, resources used to conduct the sessions, and the number and characteristics of the women served, your implementation plan can be tailored accordingly based on the information you receive. For example, you may learn that you are not reaching women aged 45–55 years and therefore need to change your marketing and recruitment strategies to target this particular age group.

Q. As the program manager, how often should I observe my staff implementing *Healthy Love*? How can this process assist in conducting process evaluation?

A. It is recommended that program managers observe the first two deliveries of *Healthy Love* to gain a clear understanding of the staff's ability to deliver the intervention, as well as to observe what activities went well and what activities need improvement. Observation is also recommended after the 6-month marker to document the facilitator's improvement and ensure that fidelity to the intervention is being maintained. Program managers should also observe any time the intervention has been adapted for a new audience. Program managers should **not** observe sessions delivered in private residences or with specific groups are not comfortable having someone watch the session. Also, the space should be large enough so the observer will be out of the line of sight for participants. It is recommended that program managers observe sessions delivered at their agency.

Facilitators should advise participants that observers will attend the session before they arrive. Advising participants of the presence of observers will allow them to choose to attend a session that will not be observed. Program Manager's observations can be used for process evaluation by ensuring fidelity to the core elements is maintained, activities are delivered as directed in the implementation manual, and questions from the Kitchen Table are correctly answered during the session.

Q. I recently observed my facilitators conducting a *Healthy Love* session and now realize that one of my facilitators does not have all the knowledge and skills required to be a *Healthy Love* facilitator. How do I address this issue if only two facilitators have been trained to implement *Healthy Love?*

A. Facilitators will often require booster trainings for facilitation skills and/or HIV/AIDS and STD information. If your observations reveal that facilitators will require booster trainings, the following steps are suggested:

- First identify a lead facilitator and meet with them to discuss their strengths, and how they can use them to enhance the knowledge and/or skills of their co-facilitator. Also explain to the lead facilitator that they will be expected to assume most of the responsibility of delivering the intervention
- Discuss the observed need with the facilitators and assure them that needing additional knowledge and skills is not a bad thing
- Identify potential trainings that facilitators can attend, secure their buy-in, and register them for the training
- After the training, observe the next couple of *Healthy Love* session deliveries and document any improvement

- Provide feedback to the facilitators and encourage continued improvement

Q. How can outcome monitoring be conducted with *Healthy Love*?

A. Some of the agencies will see women who participate in *Healthy Love* sessions on more than one occasion; in this situation you could develop a brief interview guide that asks follow-up questions about the following:

- Gauge their confidence in correctly using male and female condoms
- Ask how often they use protective barriers when having sex
- Ask about the use of female condoms, if they have tried them, do they like them as a means of protection, why or why not?
- Ask about the use of dental dams, protective barriers, and other safe sex tools, had the use of these increased since attending the session? Why or why not?
- Did attending the session increase their confidence in talking to their mate about condom negotiation, HIV and STD prevention, and HIV testing?
- Ask if they shared the information they learned from the session with friends or loved ones.

Q. How do I obtain technical assistance?

A. Technical assistance can be obtained by completing a CBA Request Information System (CRIS) at the following Web site:

http://www.cdc.gov/hiv/topics/cba/index.htm